Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
HCA HEALTHCARE
6000 NW PARKWAY STE 124
SAN ANTONIO, TX 78249

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-05-4608-01

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Carrier's Austin Representative Box
54

MFDR Date Received
FEBRUARY 25, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our records indicate that the referenced claim has not been paid according to the contract terms as determined by our agreement. OUR RECORDS INDICATE THAT THE CLAIM HAS BEEN UNDERPAID BY $19,627.72. TWCC ACCT/EXP REIMB $32374.58// TWCC STOPLOSS 75% OF TTL CHRGS $43166.10 = #32374.58/ PT RESP 0.00/ INS U/P $19627.72 FOR STOPLOSS CXH."

Amount in Dispute: $19,627.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated March 8, 2005: "… Texas Mutual Insurance Company received notification of the request for dispute resolution from HCA Healthcare. The following is the carrier's statement with respect to this dispute. This dispute involves the carrier's payment for dates of service in dispute. This dispute involves this carrier's payment for dates of service in dispute for which the requester charged $43,166.00 for four day inpatient stay for services that were NOT unusually extensive or costly. This carrier reimbursed the requester the preauthorized two day surgical per diem ($1,118) per the TWCC Acute Care In-Patient Fee Guideline. Upon review, this carrier reimbursed the requester additional days, one day surgical per diem and one day ICU. This carrier reimbursed the requester plus 10% for some implantables."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
March 22, 2004 through March 26, 2004	Inpatient Hospital Services	$19,627.72	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- M – NO MAR
- 1* YM – The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with labor code 413.011 (D). Billed charges do not meet the stop-loss method standard of the 08/01/97 acute care inpatient hospital fee guideline. The charges do not indicate an unusually costly or unusually extensive hospital stay.
- YM – The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with labor code 413.011(D).
- 3* YM – The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with labor code 413.011(D). The intent of stop-loss payment is to compensate hospital for inpatient stays that are either costly to the facility by an unusually long length of stay or the provision of unusually costly types of services. The provision of implantables through the facility does not fit either of these situations.
- O – Denial after reconsideration.
- F – Fee guideline mar reduction.
- S – Supplemental payment.
- YO – Reimbursement was reduced or denied after reconsideration of treatment/service billed.
- 2* TR – Reimbursed in accordance with the texas hospital fee guideline. Services do not appear unusually costly. Billed charges do not meet the stop-loss method standard of the 08/01/97 acute care inpatient hospital fee guideline. The charges do not indicate an unusually costly or unusually extensive hospital stay. Based on documentation submitted will allow an additional payment of 1 day surgical per diem at $1118/day and 1 day ICU per diem at $1560/day.
- YS – Supplemental payment
- TR – Reimbursed in accordance with the texas hospital fee guideline. Services do not appear unusually costly.
- INT – Interest payment.

Issues

1. Did the audited charges exceed $40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above

was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" The division concludes that the total audited charges exceed $40,000.

2. The requestor in its position statement does not address unusually extensive. As noted above, the Third Court of Appeals in its November 13, 2008 rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved…unusually extensive services." The requestor failed to discuss or demonstrate that the particulars of the admission in dispute constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 TAC §134.401(c)(6).

3. In regards to whether the services were unusually costly, the requestor does not address unusually costly. The third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must ***demonstrate*** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to discuss or demonstrate that the particulars of the admission in dispute constitute unusually costly services; therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).

4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

- Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" Review of the submitted documentation finds that the length of stay for this admission was three surgical days and one ICU/CCU; therefore the standard per diem amounts of $1,118.00 and $1,560.00 apply respectively. The per diem rates multiplied by the allowable days result in a total allowable amount of $4,914.00.

- 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed $136.00 for revenue code 390 – Blood/Stor-Proc. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue codes 390 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.
- Review of the medical documentation provided finds that although the requestor billed items under revenue code 278, itemized statement provided does not support the implantables billed. For that reason, no additional reimbursement is recommended

The division concludes that the total allowable for this admission is $4,914.00. The respondent issued payment in the amount of $12,794.03. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to discuss and demonstrate that the disputed inpatient hospital admission involved unusually extensive, and unusually costly services. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		11/9/12
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.